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Health Needs and Challenges of Women and Children in Uganda's Refugee Settlements: Conceptualising a Role for Social Work

Ms Hadijah Mwenyango¹ and Dr George Palattiyil²

Abstract: With 1.36 million refugees, Uganda has witnessed Africa's highest refugee crisis and is confronted with the subsequent protection and assistance demands. The Government of Uganda with partners are trying to support refugees to overcome the associated debilitating health conditions and recently shot to prominence in refugee management. Despite this, there are still gaps in health service provision for refugees. This paper discusses the health situation of refugee women and children living in Uganda's refugee settlements, explores the existing health service gaps and argues that there is a need to extend the role of social work in health services for refugees.

Keywords

Refugees, women and children, social work, health, health services, Uganda

Introduction

The Global Strategy for the Health of Women, Children and Adolescents 2016–2030 was launched in 2016 by the former UN Secretary-General Ban Ki-Moon. It envisioned that by the year 2030, "every woman, child, and adolescent should have rights to physical and mental health and well-being (WHO 2015, p.6). In alignment with the Sustainable Development Goals especially SDG-3 on health, this global commitment postulated three goals—surviving, thriving and transformation (WHO, 2016). Nevertheless, the Human Development Report indicates that refugees and other migrants continue to face substantial barriers to attaining the basic necessities as set out in the global strategy (UNDP, 2016) such as the right to health. Health and wellbeing are critical components of the right to life and safety. In this article, the term health is conceived to encompass a combination of both medical and sociocultural aspects and is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2006).

¹ Assistant Lecturer, Department of Social Work & Social Administration, Makerere University, Kampala, Uganda

² Senior Lecturer & MSW Programme Director, Social Work, School of Social and Political Science, University of Edinburgh

The Global Agenda for Social Work and Social Development (2012) articulates various factors which have grossly damaged the health and wellbeing of people for example, increased inequalities, wars and violence, intolerance to cultural diversity and unjust economic systems (IFSW et.al, 2012). These forces have not only jeopardised the glue that binds society but have also led to the exodus of people from their countries of origin to others that seem stable. Migration poses various health risks but can also be a social determinant of health (IOM, 2014). This is because the circumstances in which migration takes place, together with individual factors such as gender, language, immigration status, and culture, have a significant impact on health-related vulnerabilities and access to services (IOM, 2010).

The specific health issues in refugee situations have been widely covered in the literature. For example, psychological and mental health (Ssenyonga et al., 2012; Stark et al., 2015; Thomas et al., 2010; Refugee Law Project, 2015; Ewles & Simnett, 2003; Hiegel, 1991; Smyke, 1991; Karunakara et al. 2004; UNHCR, 2014); HIV/AIDS (IOM, 2009; Nyanzi, 2013; Palattiyil & Sidhva, 2015; Palattiyil & Sidhva, 2011; Wakabi, 2008); reproductive health (Mulumba, 2011; Mulumba & Wendo 2009; Crawley, 2001; WHO, 2015; Carey-Wood et al., 1995; Orach et al., 2007); and the physical and social wellbeing aspects (Cohen et.al, 2000; Chen & Land, 1986; Weiss & Lonnquist, 2003; WHO, 2010; WHO, 2016; Vingilis & Sarkella, 1997). In addition, there are studies which have focused on the gendered health needs of refugees such as violence against women and children in refugee situations (Deacon & Sullivan, 2009; Paoliso et al., 1995; Comas- Diaz & Jansen, 1995; WHO, 2016; WHO, 2015; Wakabi, 2008; Ewles & Simnett, 2003; WHO, 2007; Merry et al., 2011). This article examines the available literature and presents an exploration of the health issues faced by refugee women and children. It then suggests ways social work should intervene and respond to health needs within Uganda's refugee settlements.

Methodology

The paper focuses on analysing policy documents and reviewing the published literature on refugees and the role of social work in the protection of vulnerable refugees. The paper has drawn on official government of Uganda documents about refugees, national health policy documents, archival documents on refugees, UNHCR documents regarding policies and guidelines for health service provision, World Health Organisation (WHO) publications and reports, journal articles covering refugee health and social work, newspapers, books and

publications on refugees and service utilisation. The majority of these documents were accessed from the library, while others were obtained from official government websites, reliable publication sites and sources. Further documents were obtained from the Office of the Prime Minister of Uganda—department of refugees. The policy documents were analysed using content analysis (Bryman, 2015). We systematically examined the documents to identify concepts and key themes that were relevant to the project. The key concepts and themes formed the units of analysis and these were then used to identify potential action for social work with refugees.

The findings from the literature were complemented by the observations and the experiences of one of the authors who spent 6 months collecting data on the health services of refugees in Nakivale settlement in Uganda (from July to December 2017). This was followed by detailed discussions concerning the topic with colleagues from the department of refugees within the Office of the Prime Minister (OPM), Makerere University and the International Organisation for Migration (IOM) Uganda. The empirical data from the observations provide the basis of another article and are not discussed here.

Based on this knowledge and experience, we argue that while the Government of Uganda and its partners in refugee work are trying to support refugees there are still challenges to addressing the most pressing health needs of the vulnerable groups. In order to comprehensively meet these needs, there should be a strong commitment by policymakers to work together with professionals— social workers who possess essential knowledge, skills and the experience to effectively respond to these issues.

The argument is outlined in three parts. Firstly, we illustrate the challenge of the overwhelming number of refugees Uganda is hosting. These numbers are so large partly due to the flexible policy of refugee management, but also because of other factors such as the occurrence of war and conflict in the neighbouring countries. Secondly, we document the health needs of refugees in Uganda's settlements and we present a review of the historical context and generic role of social work in Uganda. We conclude by exploring and proposing considerations for social work practice and an integrated multi-disciplinary approach to promote a seamless practice in refugee health.

The refugee crisis in Uganda

Uganda is facing Africa's highest refugee crisis in years (UNHCR, 2019). As of March 2015, the country hosted over 430,000 refugees and asylum seekers of whom, 51% were female (OPM, 2017). By the end of 2016, Uganda was host to over half a million refugees and most of these were women and children (IRC, 2016). The scale of the problem is growing rapidly, with refugee numbers increasing from 430,000 in 2015 to 1.36 million in 2018 (UNHCR, 2019) making the country the eighth-largest refugee-hosting country in the world and the third largest refugee-hosting country in Africa (UNHCR, 2016). Refugees predominantly come from South Sudan, The Democratic Republic of Congo, Burundi, Somalia, Rwanda and other neighbouring countries (OPM, 2017). Wars, violence and persecution in the Horn of Africa and Great Lakes Region, South Sudan's conflict, insecurity and ethnic violence in the Democratic Republic of Congo (DRC) and political insecurity and human rights violations in Burundi drive significant numbers of refugees into Uganda (UNHCR, 2019). It has also been noted that Uganda's flexible refugee policy, proximity, as well as existing ethnic relations between refugees and host populations in Uganda also attract people into the country (OPM, 2017; Orach and De Brouwere, 2005). For example, some studies explain that the norms of reciprocity which exist between the Ugandans, South Sudanese and Congolese have influenced the progressive arrivals of refugees from these neighbours—as Ugandans especially from West Nile, sought refuge in Congo and Sudan around the 1980s (Orach and De Brouwere, 2005).

Of refugees, women and children are more likely to be vulnerable because they have specific health care needs normally arising from the adverse effects of war and forced migration, unhealthy environmental conditions in addition to experiences of persecution, psychological trauma, deprivation, and disrupted access to health care. Moreover, social factors arising from the reproductive role of women combined with unequal access to opportunities, information and basic health practices, further increase their health risks (WHO, 2009). These factors are also exacerbated by the fact that most of the refugees in Uganda come from low-income countries with less developed health systems.

The health needs of refugees in Uganda's settlements

The key health concerns in Uganda's refugee settlements include limited immunisation coverage for all antigens; high prevalence of controllable diseases such as malaria; and lack of latrine coverage and other sanitation facilities (Refugee Law Project, 2015). Tuberculosis, HIV/AIDS, and cancer are highly endemic in refugee settlements in Uganda leading to high rates of morbidity and mortality (Loparimoi, 2011). A disproportionate number of women and

children have acute and long-term health needs. The refugee women and children experience difficult conditions such as lack of access to basic needs—minimum essential food, basic shelter, safe drinking water and adequate sanitation facilities (UNHCR, 2019). In addition, they have limited access to health facilities and basic drugs as well as scarce access to preventive and curative information about reproductive health (UNHCR, 2019; IRC, 2014; Loparimoi, 2011). Moreover, refugee women and children are exceptionally vulnerable to social inequities, exploitation, sexual and physical abuse (UNHCR, 2019; Ssenyonga et al., 2012) which also exacerbate their risk of mental health problems.

Health services

Health services for refugees in Uganda are integrated with those of the host communities (OPM, 2015). Despite this, the organisation and implementation of health services for refugees are carried out by international, regional and indigenous agencies under the supervision and coordination of UNHCR (Orach et al., 2007). The structure for health services provided for refugees mainly compose of first-line facilities or health centres set up in the refugee settlements hence, there are no specialised hospitals for refugees which handle serious medical or surgical complications (Orach and De Brouwere, 2005). Refugees suffering from serious health complications are often referred to the designated public or NGO facilities (Orach and De Brouwere, 2005) to receive specialist treatment and care. The public health system in Uganda is experiencing acute crises such as the high prevalence of maternal mortality; infant and child mortality rates, high under-nutrition among children below five years and women of reproductive age, the HIV and an increase in other terminal illnesses like cancer (Government of Uganda, 2015). These are further impaired by underdeveloped health infrastructure (in the form of dilapidated facilities and limited staffing) and the absence of a national health insurance scheme (Mugerwa, 2013). The state is struggling to sustain the health needs of its own citizens and has limited capacity to provide adequate health services for the ‘unexpected visitors.’ Similarly, the main challenge facing intervention programmes for refugees (mainly implemented by NGOs) is underfunding and unsustainable projects. As a result, a lot of attention is put on meeting immediate humanitarian needs. This is also evidenced in the fragmented nature of services provided in the settlements (OPM, 2017) with challenges for converging both humanitarian and development needs of refugees. Limited research and the poor coordination existing between the service providers also leads to duplication of the meagre services. It is clear that significant challenges face both the government and NGOs in providing

adequate health care for refugees. However, while these challenges exist, the Government of Uganda is committed to supporting refugees and this is evidenced in their policies, which we will now examine in more depth.

Uganda's refugee policy

Uganda has shot to prominence in the recent past with regards to refugee settlement and management (OPM, 2017). An immigrant to Uganda qualifies for refugee status, if she or he proves that they are under fear of being persecuted for reasons of race, sex, religion, nationality, membership of a particular social group or political opinion in their country of nationality and/or if those persons are considered a refugee under any treaty to which Uganda is a party (The Government of Uganda, 2006). As part of managing refugees, it is the mandate of the refugee eligibility committee (REC) to decide the status of refugees. Upon receipt of refugee status, individuals get attestation/identity cards and are permitted to receive indistinguishable treatment and privileges as are generally accorded to aliens under the Constitution of the Republic of Uganda. Likewise, refugees are entitled to basic rights as set out in the 2006 Refugee Act of Uganda— a domesticated version of the 1951 UN Convention on Refugees. For example, the right to access public services like health and education; freedom of movement, land for settlement and cultivation, the right to seek employment and establish businesses as well as the right to security, legal, physical and social protection (The Government of Uganda, 2006).

Uganda operates an integrated refugee management model through which the state aims to provide humanitarian and long-term development needs for both refugees and the host communities (OPM, 2017). This model has gained further impetus with the aftermath of the New York Declaration of September 2016 which launched the Comprehensive Refugee Response Framework (CRRF). The framework accentuates the principles of admission and human rights, emergency response and ongoing needs, resilience and self-reliance, expanded solutions and voluntary repatriation (OPM, 2017). For example, the government admits and integrates refugees into the local communities by allocating them small plots of land to construct shelter, and save for the right to participate in politics, the refugees have the same rights as Ugandan's and share most of the services such as health, education and livelihoods. Omata & Kaplan (2013) contend that while Uganda has been an attractive, safe haven for

refugees due to its relative peace in the recent years, the State's friendly policies that allow refugees to live in settlements have also exacerbated the gradual increase in refugees. In line with this, the Government of Uganda has reserved land to house refugees mainly in the Northern and Western districts (UNHCR, 2016). In places with no reserved land, the department for refugees negotiates with the local communities to provide land for refugee settlement (OPM, 2015, 2017) in exchange for better infrastructure and upgraded service delivery. Today, active settlements include Kyaka II, Nakivale, Oruchinga, Kyangwali, Kiryandongo, Paralonya, Rhino Camp, Imvepi, Madi Okollo, Maaji, Bid Bidi settlement and the integrated camps of Adjumani (OPM, 2015). However, most of these areas with refugees are underdeveloped with poor infrastructure and low access to social services (OPM, 2017). Despite the country's commitment in hosting refugees, reinforced by the recent establishment of a settlement transformation agenda (OPM, 2017), refugee protection and assistance has placed inordinate pressure on available health services to a level that the Government of Uganda held a solidarity summit for refugees in 2017 to mobilise both material and financial support to promote refugee welfare.

Social work approaches

Social work is committed to human rights and has a passion to create changes within society (IFSW, 2014). More recent attempts have raised the profile of social work globally stating that: *"social work engages people and structures to address life challenges and enhance wellbeing"* (IFWS, IAASW, ICSW, 2014). This universal duty and commitment might be attained either through 'conventional' or 'progressive' approaches (Mullaly, 1997). The 'conventional' view of social work entails helping individuals adjust to existing social structures or to amend those structures in a limited way. For example, in refugee response, this can be achieved by efficient management of relief/emergency services and through casework. On the other hand, the 'progressive' view of social work aims to create social transformations of inequitable social structures rather than focusing on individuals (Mullaly, p.13). Conversely, Payne asserts that social work is either 'individualist-reformist', 'socialist-collectivist', or 'reflexive-therapeutic' (1996, p.2). For example, 'an individual reformist approach would involve therapeutic interventions such as community needs assessments, arranging for safe and fast settlement and speedy delivery of material support to individual refugees. However, a more established individual might need further support to deal with misfortune and deprivation hence the need to reflect on additional perspectives such as the utility of collective action (Lymbery, 2005).

For example, in similar circumstances, a social worker would support and empower groups of refugees to meet, interact and discuss their challenges and in addition create awareness for availability of services. In view of the various approaches to social work and given the importance of social work with refugees, it is essential for us to understand how social work practice in Uganda has developed and currently operates.

The generic role of social work in Uganda

There are many factors which influence access and utilisation of health services for refugee women and children, but social workers—acting on behalf of the government and non-governmental organisations (implementing partners) are strategically placed to have a significant impact on the design, delivery and outcomes of health services. Professional social work in Uganda is historically linked with residual service provision mainly introduced by the British Colonial Government, but the practice of social work is diverse. Long before the introduction of professional social work, social welfare provision was arranged informally. This informal social welfare system was organised around families, clans or kinship and voluntary organisations that provided social services (Twikirize, 2014). However, this system has been overstretched by emerging challenges of poverty, urbanisation, armed conflicts and civil wars, the monetised economy, HIV/AIDS epidemic and the growing culture of individualism (Twikirize, 2014). Social work in Uganda has of late mainly concentrated on wider structural issues such as poverty reduction, rehabilitation for offenders, and intervention for HIV/AIDS victims.

The training of social work students in Uganda equips them with social service delivery skills for individuals, groups or communities, and industrial based service administration. A few professional social workers are employed at the district and sub-county level as probation and welfare officers and community development officers respectively, both of which are established positions within local government decentralised service delivery systems (Twikirize 2014, p.139). Some are absorbed in the public service for example in health as medical social workers and counsellors. Notwithstanding, the majority of social workers are employed in the NGO sector/civil society organisations for instance as social workers—casework and group work, counsellors, programme officers, community mobilisers and educators, monitoring and evaluation specialists.

However, it is important to note that while social work in Uganda is well established with clearly defined functions, professional social workers assume an inadequate statutory welfare role related to legal powers for assessment and intervention in situations of need as understood in the Western model of social welfare (Palattiyil et al., 2018). This makes social work practice distorted with both non-social work professionals or unprofessional people practising social work (Twikirize, 2014). This situation is further impaired by the fact that inadequate training has been provided for social work practitioners to empower them so that they can understand the plight of vulnerable groups (Kabadaki, 1995) such as refugees. Thompson and Thompson (2016) state that 'effective social work involves a combination of knowledge, skills and values.' For example, social work practitioners who work with refugees should be conversant with the laws, policies and theories and be up-to-date with research. The skills such as assessment are critical in decision making. While values such as empathy are crucial to forming trusting relationships for tackling problems and bringing about desired changes.

The role of social workers with refugees

There is limited literature concerning the role of social work with refugees in Uganda. This is not to suggest that social work is irrelevant or is not supporting the vulnerable refugees. In fact, social work is important. However, their remit could be broader as we argue in the ensuing section. Currently, many social workers employed by the department of refugees and the local government are engaged in providing statutory protection services. Many of these are part of the refugee eligibility committee (REC) formed by ministries of internal affairs, foreign affairs, external security organisations, internal security organisations, local government and the Uganda Police. Alongside other professionals such as health workers, lawyers and security personnel, social workers perform roles like registration, documentation, adjudication on all applications for asylum; and providing physical security to refugees. In addition to protection, other social workers in the non-governmental organisations implement assistance measures provided to the refugees. For instance, their daily schedules consist of delivering relief services such as first aid, food distribution and participating in sensitisation initiatives for health promotion. Sensitisation activities are mainly organised periodically, for instance when there is an outbreak in the settlement.

Social work interventions with refugee health

There are a number of ways social work in Uganda can respond to the complex and emerging health needs of refugees. As already noted, health services in Uganda face a number of challenges such as under-funding and under-staffing, while the support for humanitarian assistance and protection programmes for refugees also face similar challenges. Underfunded humanitarian health programmes inhibit the proper design and delivery of health services to refugees and exacerbate their vulnerability to health risks. Hall (2006) alludes that for social professions, migration provides a focus for professional practice in terms of working with and supporting people with issues of relocation, integration or repatriation. The level of intervention for different countries may be varied and social work responses may vary depending on where social workers are positioned (government versus non-government), but there are common points and synergies in relation to improving health. Social workers must be prepared and committed to understanding the relevant vulnerabilities of individual refugees and their families and certainly have the will to address the international and national policy contexts which shape the structure for social service provision. They should have the capacity and determination to work on the oppressive attitudes and practices against refugees. This requires “specialized knowledge of human rights, social justice, advocacy, cultural competency, community development, problem-solving abilities and commitment to ethical practice and the awareness of relevant national and international law” (Nash et al., 2006 cited in Hall 2006, p. 196). Moreover, in addition to good interpersonal skills to work with individuals or groups of refugees, there is also an underlying expectation that social work should exercise leadership in the planning and delivery of services. For example, through identifying the health needs of refugees, communicating with providers, providing information to refugees, acting as liaison officers in the community and working as advocates for health care to ensure that requisite health services are delivered in a timely manner (Allen and Spitzer, 2016).

Given the limited and unsustainable funding available to refugee programmes, better assessment of the actual prevailing health needs of refugee women and children should be undertaken. This could be done effectively by community development officers (CDOs) who are trained in social work. Health care programmes and projects will then be better equipped to respond appropriately to need. Applying group work skills and community work approaches, social workers can liaise between refugees, government/policymakers and local communities to identify priority needs and the necessary resources (such as interpreters) to meet the needs (Hall, 2006). In this, social workers also need to prioritise the needs of the most vulnerable by

ensuring active participation of women and children in the design and implementation of health programmes. Further, the need to unlock and strengthen the resilience capacities of refugees is fundamental for developing informal care systems which would potentially assist in meeting health needs. As already noted the state provides land to refugees, social workers should train and equip refugees with skills such as how to operate and sustain businesses on the small pieces of land to generate income to cater for their health and wellbeing. There are specific examples of programmes which have been developed in some countries like Germany, United States, Switzerland, United Kingdom, Australia and Netherland such as *“language and parenting schemes for young mothers, homework clubs and or leisure activities for young people; individual and group strategies to help with job seeking, groups for children with disabilities or their siblings; and mediation and advocacy schemes”* (Hall 2006, p. 202). In addition, Cuadra (2009) also identifies examples of programmes which have been put in place to improve the health of refugees in Sweden, by health professionals, non-governmental organizations (NGOs) and churches which are not far from social work functions. These range from underground clinics, information giving, cultural mediation, interpretation services, all of which help to improve their health. These are possible ideas which practitioners in Uganda could adopt in responding to the health needs of refugees.

Moreover, social workers are well-positioned to conduct research on issues such as public health, culture and other social determinants of health to produce empirical evidence and make recommendations for health interventions. This is because they work with refugees which possibly gives them a deep understanding of their lived experiences. In line with this, they also have to reflect on the gender-responsive framework in attending to the health needs of refugee women and children such as the gender disparities and inequalities and their impact to the social determinants of health. For instance, providing small plots of land as mentioned earlier is a good initiative by the state, however, such land is often owned by the household heads who are usually male refugees. Social workers should not only bring such facts to light through conducting needs assessment research but must also play a primary role in promoting gender equality in the design and implementation of services or programmes. Al-Qdah & Lacroix (2010) in the study of Iraqi refugees in Jordan advised professionals to prioritise respect for human rights particularly women’s rights by supporting them to get access to resources and to participate in making individual and collective decisions. While empirical data is good for evidence-based practice it might also act as a tool for developing the capacity to advocate for durable solutions to the conflict and violence which force women and children into exile.

Furthermore, social workers have to mobilise and motivate refugee populations/women to actively participate in programmes and projects which are intended to improve their health and welfare like community health programmes, literacy programmes and life skills, educational or economic programmes. This would help refugees to network and be able to meet their psychosocial and emotional needs which are sometimes ignored or not prioritised by the other professional groups who work with refugees. Refugee studies elsewhere have underscored the role of social networks as essential channels of information (like guidance, support and counsel) for refugees who may be unfamiliar with the local system which further produces greater connectivity to available services (Xu & Brabeck, 2012). For example, research indicates that many refugees experience trauma especially after settling in difficult conditions (UNHCR, 2014). This is due to lack of hope, absence of employment opportunities and perceived social dysfunction. This dismal state is also aggravated by a tendency of assistance measures to simply focus on meeting the immediate needs of food, water and shelter as well as elementary health care needs, with little or not any support for mental and psychological needs (Hiegel, 1991). In other contexts, such as Canada and Australia, there have been reports of depression, anxiety and cultural shock experienced by refugees as a result of the mobility processes and procedures (Hatoss and Hujiser, 2010; George, 2012). Social workers should carry out counselling and provide psychological services to refugee women and children to help them deal with trauma and post-traumatic stress disorder. This support is also an essential element for empowering those who might have to disclose their stories to the authorities during legal processes (Palattiyil & Sidhva, 2011).

Over and above that, social workers have to communicate and disseminate information through educational programmes (Kabadaki, 1995) partly, as a way of addressing communal concerns and fears but most importantly to raise consciousness and empower refugees to reflect and re-examine cultures for the purpose of changing traditions and values which are unfair to some members of the refugee settlement area/community. For instance, one of the challenges of dealing with mental health problems among refugees relates to social contrasts in the perceptions of mental health (Xu & Brabeck, 2012). Refugees usually display their ideas of health and healing and these more often than not vary from those host communities (Hiegel, 1991; Carey-Wood et al. 1995; Ewles and Simnett, 2003). Others carry their cultural norms and practices such as female genital mutilation, gender-based violence, which pose further challenges to refugee women and children. Social workers with their unique skills, underpinned by values and empathetic practice are well positioned to address these tensions from a

culturally sensitive approach and improve the wellbeing of the victims and those deemed at risk. On top of that, medical social workers must be prepared to help refugees in coping with any health problems or injuries, offer emotional support where necessary and also educate refugees on illness management and health promotion.

Ultimately, social workers are under obligation to coordinate other social services which contribute to better health, and as well be part of/or contribute to the policymaking process regarding the design, formulation, and delivery of health and other social services. This is in keeping with Al-Qdah & Lacroix (2010) recommendation that professionals working with refugee families should also participate in structuring and budgeting of all refugee programmes in addition to their daily schedules. In line with the Global Strategy for the Health of Women, Children and Adolescents 2016–2030 (as earlier highlighted), improving elements such as nutrition, education, water, clean air, sanitation, hygiene, and infrastructure are key to accomplishing the SDGs (WHO, 2016) particularly Goal 3: health and wellbeing. To achieve this, social work professionals should work and liaise with a range of partners through research and advocacy for the rights of refugees. Moreover, there is a need for an integrated multi-disciplinary approach to a practice involving social workers and other professionals such as psychiatrists, counsellors and health workers in order to promote some seamless responses.

Conclusion

With a heightened number of refugees arriving in Uganda in recent years, the Government of Uganda faces numerous challenges in responding to the health needs of refugees particularly the most vulnerable. The Ugandan Government has good policies in place which could in fact be emulated globally to respond to similar refugee crises however, these efforts are curtailed by both institutional and professional challenges. The need for engagement between the government, partners and social professionals (especially social workers) in planning, programming, implementing, reviewing and evaluation of health service delivery for this vulnerable group is central since these possess essential knowledge, skills and experience. These are all intrinsic to making appropriate assessments and effective responses to the health needs of refugee women and children. Currently, there are challenges, but there is potential that social work could be doing a lot more (as demonstrated by the examples in other countries) and presumably, it would have the backing of the government to get more involved. Social care professionals are well placed to respond to individuals and families who have been adversely affected by loss and trauma associated with the reasons for migration. They are also

able to work on the local policies and community attitudes that discriminate and exclude refugees from the social order (Hall, 2006). The need to improve refugees' access to welfare services like health care is urgent because it has an impact on their individual worth and dignity. In a wider societal sense, ignoring their public health concerns would cause negative consequences to the development of the country.

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